



CENTRAL SERVICES DIVISION
PROCESSING CENTER
555 WRIGHT WAY
CARSON CITY, NV 89711
(775) 684-4850
www.dmvnv.com

SELF-INSURANCE LOSS EXPERIENCE RECORD

(NAC 485.060 and NAC 485.110)

Name _____

Report for Calendar Year _____ Assigned Number _____

(If new applicant, please leave blank)

Taxicab companies must provide records for annual costs of claims during the immediately preceding three (3) years.

Total number of accidents		
Total number of claims submitted		
Total number of claims paid and total dollar amount		
Total number claims not paid and total dollar amount		
Total number of accidents, no claim submitted		
Total number of claims against		
Grand total dollar amount		
Total number paid through litigation (use an additional sheet if needed.)		
Case Number	Demand	Paid
Totals		

☐ Yes ☐ No All claims were settled by the above named company.
☐ Yes ☐ No All claims were settled by an adjusting company, adjusting company's name _____ and license number _____

I hereby certify all statements made in this report are true and correct. I fully understand false statements are cause for cancellation of the certificate of Self-Insurance. This report must be filed annually at least 15 days before expiration.

NOTE: TO BE SIGNED BY SOLE OWNER, PARTNER, OR OFFICER OF THE CORPORATION ONLY.

Printed Name _____

Title _____

Signature _____

Date _____

Subscribed and sworn before me this _____ day of _____, _____

Notary Public or Authorized Nevada DMV Representative _____